



How Stigma and Other Factors Perpetuate the HIV Crisis – and How to Fix It

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President Trump recently announced a plan to end the U.S. HIV and AIDS epidemic by 2030. The approach includes four pillars: diagnosing those living with HIV; getting those diagnosed on medication as soon as possible; encouraging the use of proven HIV prevention approaches; and responding rapidly to detect and reduce HIV infection clusters. Taken together, these pillars comprise the necessary medical tactics required to end the epidemic. However, several social and political factors, if left unaddressed, will likely prevent this plan from ending the epidemic. Fortunately, policy efforts in California and Canada offer promising solutions to these problems.

The Medical, Social, and Political Contexts of the Epidemic

Medical researchers have proven that people living with HIV can take a daily medicine, suppress the virus in their blood, and be free from the risk of transmitting HIV. New HIV prevention tools, including pre-exposure prophylaxis – called PrEP, or the birth-control pill for HIV – have also dramatically reduced risk of HIV infection. PrEP research shows that, among gay and bisexual men who take the pill daily, there have been zero HIV infections. This new science indicates that zero HIV infections are a possibility.

However, of the 1.2 million people living with HIV, 165,000 do not know they are infected. Over 80% of new HIV infections occur because those living with HIV have been unable to take the steps to suppress the virus in their system due to many structural barriers. Between 2014 and 2016, only 7% of the estimated 1.1 million people living in the United States who could receive prescriptions to prevent HIV did so.

More concerning is that although Black queer men account for 50% of the estimated 1.1 million PrEP eligible persons, only 1% of those filling PrEP prescriptions were black queer men. This is particularly concerning given the fact that white and heterosexual people saw an 18% and 36% decline in HIV, respectively, while rates of HIV infection increased 35% among 25-34 year old gay or bisexual males; 20% among all gay and bisexual Latino males; and increased 22% among all gay or bisexual black males. Most concerning is the 87% increase in diagnoses among 13 to 24-year-old gay and bisexual black men. Although the Centers for Disease Control and Prevention noted disparities in HIV infection rates as early as the 1990s, not much has changed. The black community is still the most heavily burdened. If we do not address this inequity, some researchers estimate that “one half of gay and bisexual black men will be diagnosed with HIV in their lifetime.”

In order to make a 2030 end to the epidemic a reality, medical professionals and policymakers need to understand the complex nature of HIV infection risk and the lives of those affected by this risk. Too many people continue to believe the false narrative that HIV infection is a result of a person’s choices or behaviors. Black gay and bisexual men use condoms more, have less sexual partners, and use drugs less than White gay

and bisexual men. However, they are infected with HIV more and faster. The mismatch between these risk-lowering behaviors and worse outcomes can be explained by the racist structures with which Black Americans must live.

Take, for example, the fact that although PrEP is almost 100% effective, doctors are less willing to prescribe PrEP to Black gay and bisexual men because they “fear” they will be more sexually promiscuous. These same racial biases and stigma keep Black Americans from seeking healthcare services and from testing for HIV, a critical first step in HIV prevention.

Too often, doctors are also unwilling to disclose evidence to their patients about how suppressing the virus in one’s system can eliminate the risk of transmitting it. Only 42% of primary care providers and 77% of infectious disease specialists discuss this with their patients who have become undetectable. The providers who withhold this information report that they do so because they do not believe the scientific evidence, they believe that sharing this would negate personal responsibility, or they have other concerns about how sharing this information would change patients’ behaviors.

These horrifically paternalistic attitudes violate the Hippocratic Oath to “do no harm.” These providers’ failure to discuss the available evidence does harm by exacerbating HIV risk. Their patients, lack important information about their health and available treatments and prevention measures. Such stigmatization harms queer men, and black queer men in particular.

Ways Forward

Policies and regulations need to align with the latest scientific evidence. Sexual behaviors are manipulated by numerous factors, especially stigma and poor mental health. The Government of Canada recognizes poor mental health as a risk for HIV, given the evidence that directly links issues of depression to reduced ability to use condoms. Meanwhile, the U.S. Centers for Disease Control and Prevention and U.S Preventive Services Task Force have PrEP guidelines, but their eligibility criteria are outdated because they focus solely on sexual behaviors. As noted earlier, black queer men use more condoms and have less sexual partners. Under these criteria, black queer men would not be eligible, though they face the greatest risk and could benefit the most from access to the medication. To improve decision makers should work to:

- Create policies and regulations that encompass the real-life factors related to white and black queer men’s elevated HIV risk.
- Ensure treatment and preventative medication is equitably distributed to those with historical and manipulated risk.
- Follow California’s lead by legally mandating that doctors talk to all eligible patients about PrEP. Such laws help ensure everyone receives up-to-date information and can remove the detrimental effects of physicians’ racial biases. California is also exploring laws allowing pharmacists to prescribe PrEP, further reducing the systemic barriers facing those from marginalized groups.

While it is difficult to incorporate the lived experiences of stigma into policy and practice, it is an essential step in ending the HIV epidemic by 2030. President Trump’s plan requires new strategies to achieve its goal. All the biomedical means necessary for ending the epidemic are available. However, the only way to end the U.S. HIV epidemic is to ensure medical professionals, advocates, and policymakers understand the social and

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structural barriers faced by those at risk of HIV infection.

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